

chapter for a Part D eligible individual who is a retired participant or the spouse or dependent of a retired participant under the coverage.

Qualifying covered retiree means a Part D eligible individual who is: a participant or the spouse or dependent of a participant; covered under employment-based retiree health coverage that qualifies as a qualified retiree prescription drug plan; and not enrolled in a Part D plan. For this purpose, the determination of whether an individual is covered under employment-based retiree health coverage is made by the sponsor in accordance with the rules of its plan. For purposes of this subpart, however, an individual is presumed not to be covered under employment-based retiree health coverage if, under the Medicare Secondary Payer rules in § 411.104 of this chapter and related CMS guidance, the person is considered to be receiving coverage by reason of current employment status. The presumption applies whether or not the Medicare Secondary Payer rules actually apply to the sponsor. For this purpose, a sponsor also may treat a person receiving coverage under its qualified retiree prescription drug plan as the dependent of a qualifying covered retiree in accordance with the rules of its plan, regardless of whether that person constitutes the qualifying covered retiree's dependent for Federal or State tax purposes.

Retiree drug subsidy amount, or subsidy payment, means the subsidy amount paid to sponsors of qualified retiree prescription drug coverage under § 423.886(a).

Standard prescription drug coverage is defined in § 423.100 of this part.

Sponsor is a plan sponsor as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(16)(B), except that, in the case of a plan maintained jointly by one employer and an employee organization and for which the employer is the primary source of financing, the term means the employer.

Sponsor agreement means an agreement by the sponsor to comply with the provisions of this subpart.

§ 423.884 Requirements for qualified retiree prescription drug plans.

(a) *General.* Employment-based retiree health coverage is considered to be a qualified retiree prescription drug plan if all of the following requirements are satisfied:

(1) An actuarial attestation is submitted in accordance with paragraph (d) of this section. The rules for submitting attestations as part of subsidy applications are described in paragraph (c) of this section.

(2) Part D eligible individuals covered under the plan are provided with creditable coverage notices in accordance with § 423.56.

(3) Records are maintained and made available for audit in accordance with paragraph (f) of this section and § 423.888(d).

(b) *Disclosure of information.* The sponsor must have a written agreement with its health insurance issuer (as defined in 45 CFR 160.103), or group health plan (as applicable) regarding disclosure of information to CMS, and the issuer or plan must disclose to CMS, on behalf of the sponsor, the information necessary for the sponsor to comply with this subpart.

(c) *Application*—(1) *Submitting an application.* The sponsor (or its designee) must submit an application for the subsidy to CMS that is signed by an authorized representative of the sponsor. The application must be provided in a form and manner specified by CMS.

(2) *Required information.* In connection with each application the sponsor (either directly or through its designee) must submit the following:

(i) Employer Tax ID Number (if applicable).

(ii) Sponsor name and address.

(iii) Contact name and email address.

(iv) Actuarial attestation that satisfies the standards specified in paragraph (d) of this section and any other supporting documentation required by CMS for each qualified retiree prescription drug plan for which the sponsor seeks subsidy payments.

(v) A list of all individuals the sponsor believes (using information reasonably available to the sponsor when it submits the application) are qualifying covered retirees enrolled in each prescription drug plan (including spouses

and dependents, if Medicare-eligible), along with the information about each person listed below in this paragraph:

- (A) Full name.
- (B) Health Insurance Claim (HIC) number or Social Security number.
- (C) Date of birth.
- (D) Gender.
- (E) Relationship to the retired employee.
- (vi) A sponsor may satisfy paragraph (c)(2)(v) of this section by entering into a voluntary data sharing agreement (VDSA) with CMS (or any other arrangement CMS may make available).
- (vii) A signed sponsor agreement.
- (viii) Any other information specified by CMS.

(3) *Terms and conditions.* To receive a subsidy payment, the sponsor (through the signed sponsor agreement or as otherwise specified by CMS) must specifically accept and agree to:

- (i) Comply with the terms and conditions of eligibility for a subsidy payment set forth in this regulation and in any related CMS guidance;
- (ii) Acknowledge that the information in the application is being provided to obtain Federal funds; and
- (iii) Require that all subcontractors, including plan administrators, acknowledge that information provided in connection with the subcontract is used for purposes of obtaining Federal funds.

(4) *Signature by sponsor.* An authorized representative of the requesting sponsor must sign the completed application and certify that the information contained in the application is true and accurate to the best of the sponsor's knowledge and belief.

(5) *Timing.* (i) *General rule.* An application for a given plan year must be submitted by no later than 90 days prior to the beginning of the plan year, unless a request for an extension has been filed and approved under procedures established by CMS.

(ii) *Transition rule.* For plan years that end in 2006, an application must be submitted by September 30, 2005 unless a request for an extension has been filed and approved under procedures established by CMS.

(6) *Updates.* The sponsor (or the designee) must provide updates to CMS in a manner specified by CMS of the in-

formation required in paragraph (c)(2) of this section on a monthly basis or at a frequency specified by CMS.

(7) *Data match.* Once the full application for the subsidy payment is submitted, CMS—

(i) Matches the names and identifying information of the individuals submitted as qualifying covered retirees with the Medicare Beneficiary Database (MBD) to determine which retirees are Part D eligible individuals who are not enrolled in a Part D plan.

(ii) Provides information concerning the results of the search in paragraph (c)(7)(i) of this paragraph (such as names and other identifying information, if necessary) to the sponsor (or to a designee).

(d) *Actuarial attestation-general.* The sponsor of the plan must provide to CMS an attestation in a form and manner specified by CMS that the actuarial value of the retiree prescription drug coverage under the plan is at least equal to the actuarial value of the defined standard prescription drug coverage (as defined at § 423.100). The attestation must meet all of the following standards.

(1) Contents of the attestation include the following assurances:

(i) The actuarial gross value of the retiree prescription drug coverage under the plan for the plan year is at least equal to the actuarial gross value of the defined standard prescription drug coverage under Part D for the plan year in question.

(ii) The actuarial net value of the retiree prescription drug coverage under the plan for that plan year is at least equal to the actuarial net value of the defined standard prescription drug coverage under Part D for the plan year in question.

(iii) The actuarial values must be determined using the methodology in paragraph (d)(5) of this section.

(2) The attestation must be made by a qualified actuary who is a member of the American Academy of Actuaries. Applicants may use qualified outside actuaries, including (but not limited to) actuaries employed by the plan administrator or an insurer providing benefits under the plan. If an applicant

uses an outside actuary, the attestation can be submitted directly by the outside actuary or by the plan sponsor.

(3) The attestation must be signed by a qualified actuary and must state that the attestation is true and accurate to the best of the attester's knowledge and belief.

(4) The attestation must contain an acknowledgement that the information being provided in the attestation is being used to obtain Federal funds.

(5) Methodology. (i) *Basis of the attestation.* The attestation must be based on generally accepted actuarial principles and any actuarial guidelines established by CMS in this section or in future guidance. To the extent CMS has not provided guidance on a specific aspect of the actuarial equivalence standard under this section, an actuary providing the attestation may rely on any reasonable interpretation of this section and section 1860D–22(a) of the Act consistent with generally accepted actuarial principles in determining actuarial values.

(ii) *Specific rules for determining the actuarial value of the sponsor's retiree prescription drug coverage.* (A) The gross value of coverage under the sponsor's retiree prescription drug plan must be determined using the actual claims experience and demographic data for Part D eligible individuals who are participants and beneficiaries in the sponsor's plan, provided that sponsors without creditable data due to their size or other factors, may use normative databases as specified by CMS. Sponsors may use other actuarial approaches specified by CMS as an alternative to the actuarial valuation specified by this paragraph (d)(5)(ii)(A).

(B) The net value of coverage provided under the sponsor's retiree prescription drug plan must be determined by reducing the gross value of such coverage as determined under paragraph (d)(5)(ii)(A) of this section by the expected premiums paid by Part D eligible individuals who are plan participants or their spouses and dependents. For sponsors of plans that charge a single, integrated premium or contribution to their retirees for both prescription drug coverage and other types of medical coverage, the attestation must allocate a portion of the premium/con-

tribution to prescription drug coverage under the sponsor's plan, under any method determined by the sponsor or its actuary.

(iii) *Specific rules for calculating the actuarial value of defined standard prescription drug coverage under Part D.* (A) The gross value of defined standard prescription drug coverage under Part D must be determined using the actual claims experience and demographic data for Part D eligible individuals in the sponsor's plan, provided that sponsors without creditable data due to their size or other factors may use normative databases as specified by CMS. Sponsors may use other actuarial approaches specified by CMS as an alternative to the actuarial valuation specified by this paragraph (d)(5)(iii)(A).

(B) To calculate the net value of defined standard prescription drug coverage under Part D, the gross value of defined standard prescription drug coverage under Part D as determined by paragraph (d)(5)(iii)(A) of this section is reduced by the following amounts:

(1) The monthly beneficiary premiums (as defined in § 423.286) expected to be paid for standard prescription drug coverage; and

(2) An amount calculated to reflect the impact on the value of defined standard prescription drug coverage of supplemental coverage provided by the sponsor. Sponsors may use other actuarial approaches specified by CMS as an alternative to the actuarial valuation specified in this paragraph (d)(5)(iii)(B)(2).

(C) The valuation of defined standard prescription drug coverage for a given plan year is based on the initial coverage limit cost-sharing and out-of-pocket threshold for defined standard prescription drug coverage under Part D in effect at the start of such plan year. The attestation, however, must be submitted to CMS no later than 60 days after the publication of the Part D coverage limits for the upcoming calendar year otherwise, such valuation is based on the initial coverage limit, cost-sharing amounts, and out-of-pocket threshold for defined standard prescription drug coverage under Part D for the upcoming calendar year.

(D) Example. If a sponsor's retiree prescription drug plan operates under a

plan year that ends March 30, the attestation for the year April 1, 2007–March 30, 2008 is based on the coverage limit, cost-sharing and out-of-pocket threshold that apply to defined standard prescription drug coverage under Part D in 2007 provided the attestation is submitted within 60 days after the publication of the Part D coverage limits for 2008. If the attestation is submitted more than 60 days after the 2008 coverage limits have been published, the 2008 coverage limits would apply.

(iv) Employment-based retiree health coverage with two or more benefit options. For the assurance required under paragraph (d)(1)(i) of this section, the assurance must be provided separately for each benefit option for which the sponsor requests a subsidy under this subpart. For the assurance required under paragraph (d)(1)(ii) of this section, the assurance may be provided either separately for each benefit option for which the sponsor provided assurances under paragraph (d)(1)(i) of this section, or in the aggregate for all benefit options for which the sponsor provided assurances under paragraph (d)(1)(i) of this section.

(6) Timing. (i) *Annual submission.* The attestation must be provided annually at the time the sponsor's subsidy application is submitted, or at such other times as specified by CMS in further guidance.

(ii) *Submission following material change.* The attestation must be provided no later than 90 days before the implementation of a material change to the drug coverage of the sponsor's plan that impacts the actuarial value of the coverage.

(e) *Disclosure of creditable prescription drug coverage status.* The sponsor must disclose to all of its retirees and their spouses and dependents eligible to participate in its plan who are Part D eligible individuals whether the coverage is creditable prescription drug coverage under § 423.56 in accordance with the notification requirements under that section.

(f) *Access to records for audit.* The sponsor (and where applicable, its designee) must meet the requirements of § 423.888(d). Failure to comply with § 423.888(d) may result in nonpayment

or recoupment of all or part of a subsidy payment.

§ 423.886 Retiree drug subsidy amounts.

(a) *Amount of subsidy payment.* (1) For each qualifying covered retiree enrolled with the sponsor of a qualified retiree prescription drug plan in a plan year, the sponsor receives a subsidy payment in the amount of 28 percent of the allowable retiree costs (as defined in § 423.882) in the plan year for such retiree attributable to gross retiree costs between the cost threshold and the cost limit as defined in paragraph (b) of this section. The subsidy payment is calculated by first determining gross retiree costs between the cost threshold and cost limit, and then determining allowable retiree costs attributable to the gross retiree costs. For this purpose and where otherwise relevant in this subpart, plan year is the calendar, policy, or fiscal year on which the records of a plan are kept.

(2) *Transition provision.* For a qualified retiree prescription drug plan that has a plan year which begins in calendar year 2005 and ends in calendar year 2006, the subsidy for the plan year must be determined in the following manner. Claims incurred in all months of the plan year (including claims incurred in 2005) are taken into account in determining which claims fall within the cost threshold and cost limit for the plan year. The subsidy amount is determined based only on costs incurred on and after January 1, 2006.

(b) *Cost threshold and cost limit.* The following cost threshold and cost limits apply—

(1) Subject to paragraph (b)(3) of this section, the cost threshold under this section is equal to \$250 for plan years that end in 2006.

(2) Subject to paragraph (b)(3) of this section, the cost limit under this section is equal to \$5,000 for plan years that end in 2006.

(3) The cost threshold and cost limit specified in paragraphs (b)(1) and (b)(2) of this section, for plan years that end in years after 2006, are adjusted in the same manner as the annual Part D deductible and the annual Part D out-of-pocket threshold are adjusted annually